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VIA EMAIL

February 3, 2012

Ms. Amy Tibor
Planning Associate, Health Insurance Exchange
State of Connecticut
Office of Policy and Management
450 Capitol Avenue, MS 52HIE
Hartford, CT 06106-1379

RE: Mercer Report-Comments on Recommendations for Tiered Prescription Drug Plan and Co-Insurance

Dear Ms. Tibor:

The Arthritis Foundation has reviewed Mercer's final report to the Exchange Board. While we do not have expertise to comment on many of the insurance recommendations, we read with concern Mercer's recommendations for using tiers and coinsurance in prescription drug plans as cost-saving measures. Our concerns with these approaches relate to affordability and accessibility to newer specialty medications, specifically for a class of medications called biologic response modifiers. This class of medications is used to prevent joint destruction and related disability in certain forms of inflammatory arthritis, such as rheumatoid and psoriatic arthritis. Similar medications are indicated for other chronic diseases, such as lupus, multiple sclerosis, cancer, Crohn's disease, and hemophilia. It is important to note that there are currently no generic alternatives for biologics.

The Arthritis Foundation is alarmed about the negative effects that excessive copayments, coinsurance, or specialty tiers have on access for appropriate therapy for people with inflammatory arthritis. Specialty tiers are often labeled as a fourth or fifth tier above the third tier for non-preferred brand. Specialty tiers often use coinsurance or require the insured to pay a percentage of the total cost of the medication rather than a fixed amount. In commercial private plans, this cost-sharing can be anywhere from 20-50% of the total drug cost. The yearly cost for the biologic medications ranges from $12,000-$48,000. Thus, in addition to premiums and co-pays, insureds may be asked to pay anywhere from $2,400 to $24,000 per year out-of-pocket.

The Kaiser Family Foundation reports that in 2009, over three-quarters (78%) of workers with prescription drug coverage were in plans with four tiers of drug coverage[1]. The chart on Newer Initiatives Expand Approaches to Control Costs (Mercer Report, page 103), shows that 55% of large employers nationally used co-insurance in prescription drug plans. Mercer reports (page 107) that large employers have found that introducing a 30% coinsurance with a maximum of $80 results in consumers making more informed choices.

We have found from studies, published in peer reviewed scientific journals, and reports from people using the biologic medications that more and more policies use a straight percentage with no maximum. The result is that out-of-pocket costs force folks to use older medications that only treat symptoms or slow but not prevent joint destruction. High out-of-pocket costs can also result in using no medication because the older generics no longer effectively control symptoms or disease progression.

Polinksi and colleagues reported that for those with rheumatoid arthritis out-of-pocket costs exceeded $4,000 annually in 2006 in all cost-sharing schemes under Medicare Part D[2]. The study authors noted that the majority of costs for specialty biologic medications are shifted to beneficiaries, which may place these medications out their reach.

Goldman and colleagues completed a study that analyzed the change in member's utilization given a change in their cost-sharing for specialty medications, including rheumatoid arthritis[3]. The study included pharmacy and medical claims from 55 health plans offered by 15 large employers with 1.5 million beneficiaries in 2003-2004. The study showed that doubling the co-pay (which is a fixed amount usually less than co-insurance) resulted in a 21% reduction in use among people with rheumatoid arthritis.

A 2009 study by some of the same team of authors concluded that high cost sharing delays the initiation of drug therapy for patients newly diagnosed with chronic disease[4]. In rheumatoid arthritis, studies showed that most of the joint damage occurs in the first three years of the disease. Any delay increases the risk for lifelong disability from irreversible joint destruction.

A meta-analysis by Andrew and colleagues in 2003 found that out-of-pocket expenses greater than $100 for tumor necrosis factor (TNF) blockers--the most widely used biologic for rheumatoid arthritis--
and greater than $200 for multiple sclerosis therapies were associated with increased prescription abandonment[5].

In 2010, New York was the first state to pass legislation prohibiting the use of specialty tiers. Similar proposals were introduced last year in five of the six New England states, including Connecticut.

We urge the Exchange Board to carefully examine negative consequences on access and affordability of shifting costs to beneficiaries in order to save premiums and other costs for employers and individuals. We further recommend that Exchange Board consider regulating specialty tiers for plans in the Exchange by capping out-of-pocket maximums in order to insure affordability and thus accessibility to these medications.

Sincerely,

Paula Haney, RPT
Chair, Regional Public Policy Committee
Windham

[1] Kaiser Family Foundation. Employer Health Benefits 2009 Annual Survey. September 2010

[2] Polinski JM, Mohr PE, Johnson L. Impact of Medicare Part D on access to and cost sharing for specialty biologic medications for beneficiaries with rheumatoid arthritis. *Arthritis Rheum* 2009: 61-745-54

[3] Goldman DP, Joyce GF, Lawless G et al: Benefit design and specialty drug use. *Health Aff.* 2006 25(5): 1319-31

[4] Solomon MD, Goldman DP, Joyce GF, Escare JJ. Cost-sharing and the initiation of drug therapy for the chronically ill. *Arch Intern Med*. 2009 169(8):740-748.

[5] Andrew MP, Takiya L, Finley R. Meta-analysis of trials of interventions to improve medication adherence. American Journal of Health System Pharmacies, 2003: 60 (7).